Solving the Mystery of the Adult/Adolescent HIV and AIDS Case Report Form New Highlights

Clinical Data and Research Indiana State Department of Health 800-376-2501

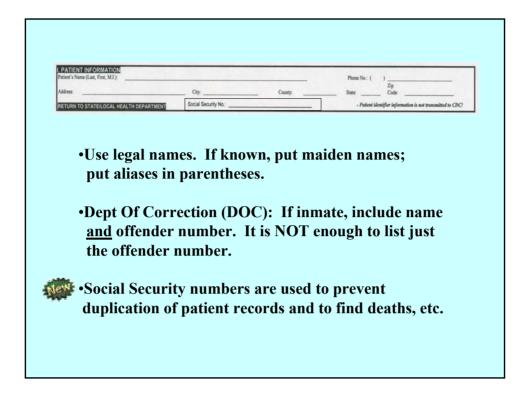
HIV/AIDS Case Report Forms

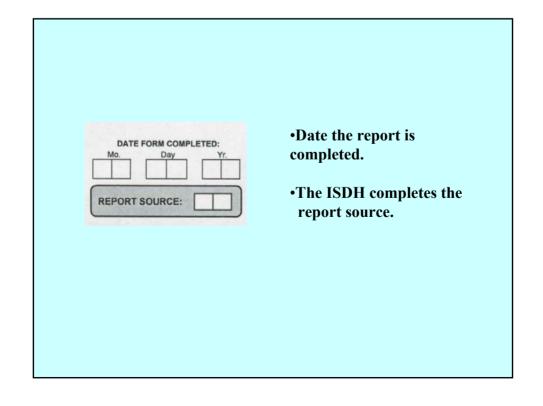
The HIV/AIDS case report forms, both adult and pediatric, began collecting additional information January 1, 2003.

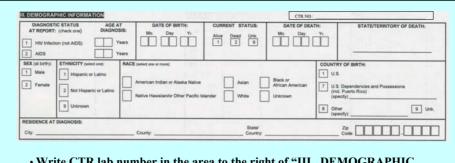
Accurate, thorough, case reports provide demographic information regarding the spread of the HIV/AIDS infection.

Reporting sex, race, ethnicity, and behavior allows us to to gear programs toward specific populations and areas of need.

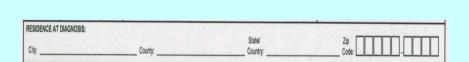
Case reports need to be initiated within 72 hours of receipt of a confirmatory test. All HIV-infected pregnant women must be reported immediately. All babies born to HIV-infected or AIDS-diagnosed mothers must be reported immediately after birth.







- Write CTR lab number in the area to the right of "III. DEMOGRAPHIC INFORMATION". (This is the same as the OPSCAN number.)
- •There are many people with the same first and last names; Date of Birth is used to differentiate cases.
- •If aware of a patient's death, note the date, cause, and state where the person died. (Send a copy of the death certificate, if available.)
- Fig. The federal government now requires the separation of ethnicity and race.
- E-Each reporter is to select one option in the Ethnicity field, and as many as apply in the Race field.
- •Complete the Country of Birth; if born outside of the US, write in the country.

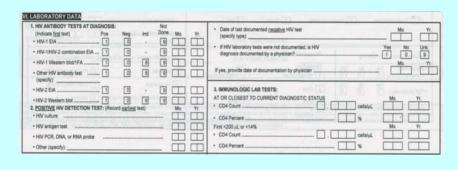


- •The residence at first diagnosis <u>may not be the patient's current address</u> include the county and the state
- •If residence was not an Indiana address, the ISDH will contact the other state to determine if the person has already been reported. That person will be reflected in Indiana prevalence.

Be specific!	Facility Name City			
The facility of <u>first</u> diagnosis may be in ndiana or another state	State/Country FACILITY SETTING (check one)			
The facility of <u>first</u> diagnosis may be different from the facility where the form is being completed.	1 Public 2 Private 3 Federal 9 Unk. FACILITY TYPE (check one)			
•Facility type "other" could include: ER, coroner, medicine clinic, etc.	01 Physician, HMO 26 Prenatal/OB clinic 15 Case Management Agency 30 Correction facility 20 HRSA Clinic 31 Hospital, Inpatient			
,,,,	22 Counseling & Testing Site 32 Hospital, Outpatient 24 Drug treatment center 88 Other (specify):			

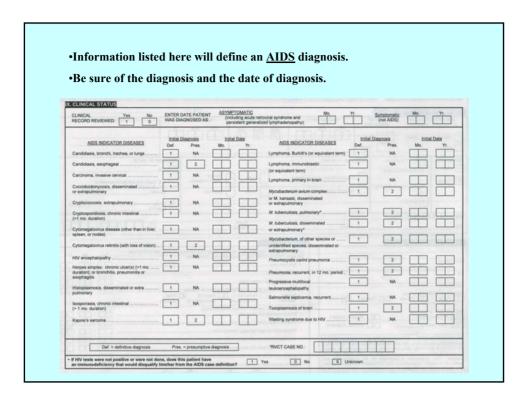
AFTER 1977, AND PRECEDING THE FIRST POSITIVE DIAGNOSIS FOR HIV INFECTION OR AIDS, THIS PATIENT HAD (Respond to ALL Categories):	Yes	No	Unk.
Sex with male	[1]	0	9
Sex with female			9
Injected nonprescription drugs		0	9
Received clotting factor for hemophilia/coagulation disorder. Specify 1 Factor VIII 2 Factor IX 8 Other disorder. (Hemophilia B) (Specify):	1		9
HETEROSEXUAL relations with any of the following:			
Intravenous/injection drug user		0	9
Bisexual male		0	9
Person with hemophilia/coagulation disorder Transfusion recipient with documented HIV infection		0	9
Translation recipient with documented HIV infection		0	9
Person with AIDS or documented HIV infection, risk not specified			9
Received transfusion of blood/blood components (other than clotting factor) Mo. Yr. Mo. Yr. First Last Last Received transplant of tissue/organs or artificial insemination Worked in a health-care or clinical laboratory setting (specify occupation):	1	0	9 9
Patient History is important in determining a pource of exposure to HIV. Many agencies use this information to develop a	erson's	prol	bable
dical social services and prevention programs	!		
edical social services and prevention programs			
f not completed or marked "Unk.", a DIS refei	ral wil	l be ı	made

- •If no laboratory data is provided, there must be documentation by a physician.
- •A CD4 is not a definitive diagnosis. A positive Western blot or physician diagnosis is needed.
- •A CD4 of <u>less than</u> 200 or 14% along with confirmed HIV is definitive for a diagnosis of AIDS



VII. PHYSICIAN INFORMAT	ON		
Physician's Name.		Phone No.: ()	Medical Record No.
	(Last, First, M.I.)		il i
		Person	
Hospital/Facility:		Completing Form:	Phone No.: ()
	- Phys	sician identifier information is not transmitted to	o CDC! -

- •The physician's first and last names and phone number are crucial. The phone number is needed to contact the physician quickly for further information or clarification.
- •Please include the medical record number if available.
- •Hospital/Facility is the place the patient/client is receiving care.
- •Person Completing Form requires the first & last names and their phone number in case that person needs to be contacted.



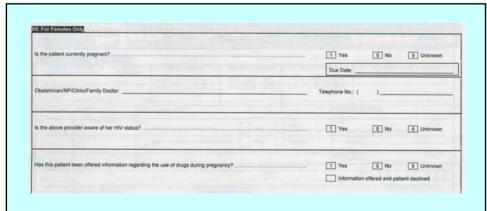
Has this patient been informe	ed of his her HIV infection?	1 Y	es 🗓 No	9 Unk	This patient is receiving or has been referred for
This patient's partners will be	e notified about their HIV exposure a	nd counseled by:			HIV-related medical services 1 0 -
1 Health department	2 Physician/provider	3 Patient	9 Unk		Substance abuse treatment services 1 0 8
					Mental health services

- Lach patient must be informed of their infection.
- •Mental Health Services may specify bipolar, schizophrenia, paranoia, depression, non-inject drugs, alcohol, suicide
 - •This information tells us what services are being accessed.

(Again, if the ISDH cannot determine if a person has been informed of their infection, or if partners have been notified, a DIS referral will be made.)

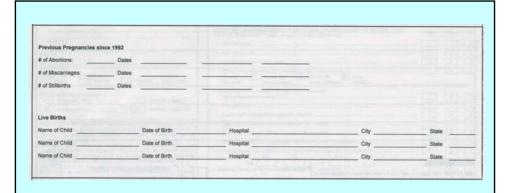
- •The person providing post-test counseling may not be the person completing the form. The record needs the name and phone number of the person doing the post-test counseling.
- •If this section is blank or marked "No" or "Unk", a DIS referral will be made.
- •If unable to verify post-test counseling on patient's diagnosis since 1997, a DIS referral will be initiated.

II. Post-Test Counseling				
Has the patient been told not to donate blood, plasma, organs, or other body tissue?	1 Yes	0 No	9 Unk	Date
Has this patient been told of their duty to warm all sex and needle-sharing partners of their HIV status prior to engaging in this behavior?	1 Yes	0 No	9 Unk	Date
Name of person that provided post-test counseling		Telephone	No.: ()_	



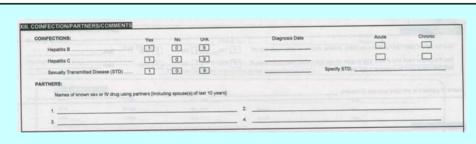
COMPLETE THIS SECTION FOR ALL FEMALES

- •Is patient currently pregnant?
- •Date of expected delivery.
- •Health care provider's name and phone number.
- •Does health care provider know patients HIV status?
- •Offered information regarding use of drugs during pregnancy?



- •Previous Pregnancies since 1992:
- •Live Births:
 Please list name of child, date of birth, hospital, city, and state.

Helpful comments could include the HIV testing status of each child.



This is a new section. Co-infections and Partners.



•Co-infections:



Hepatitis B and C

Sexually transmitted disease (STD)

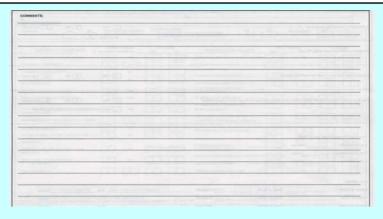
Specify which STD- chlamydia, gonorrhea, syphilis, HPV, herpes, other.

Date of diagnosis is important to care and prevention



•Partners:

Sex partners including spouse(s) of last 10 years IV drug using partners



COMMENTS

•Use this section for any other pertinent information such as:

Has spouse/partner been tested or reported?

Has patient been referred to care coordination?

If so, coordinator's name, location and phone number.

Is patient from another state/country? If so, were they diagnosed there?

Are there any reported symptoms, such as previous pneumonia, cancer, etc?

If patient has children, have they been tested? If positive have they been reported?

List any other miscellaneous information you feel may be useful.

If you are aware of an HIV-positive child under 13 years of age and/or a woman with HIV that just delivered, contact your surveillance department for assistance in completing the appropriate forms.

Surveillance Contacts

Elkhart, Lake, LaPorte, - Sue Ann Mellon Porter, Newton, Jasper, (219) 755-3030

St. Joseph or White Counties

Marion County - (317) 221-2132

All other counties, call ISDH Surveillance toll free (800) 376-2501